ANNUAL REPORT

Federal Fiscal Year 1998 (FFY 98)

CONNECTICUT

CHILD HEALTH STATE PLAN OPERATION INFORMATION

The purpose of this Annual Report is to provide a brief description of the operation of Connecticut's Child Health State Plan.

A. Baseline Estimates

The baseline estimates of the number of uninsured children in Connecticut are:

HUSKY A:	≤ 185% FPL	53,000
HUSKY B:	Band 1: > 185% ≤ 235% FPL	15,300
	Band 2: > 235% ≤ 300% FPL	7,000
	Band 3: > 300%	14,400
Total		89,700

B. Reduction of Low-Income Children without Insurance

Reduction of the number of children without insurance can be seen in the following enrollment statistics, which show actual enrollment in HUSKY A and B during the time periods specified:

For the Period 7/1/98 through 9/30/98:

HUSKY A:	≤ 185% FPL	2,964
HUSKY B:	Band 1: > 185% ≤ 235% FPL	776
	Band 2: > 235% ≤ 300% FPL	325

	Band 3: > 300%	38
Total		4,103

For the Period 10/1/98 through 12/31/98:

HUSKY A:	≤ 185% FPL	5,741
HUSKY B:	Band 1: > 185% ≤ 235% FPL	761
	Band 2: > 235% ≤ 300% FPL	349
	Band 3: > 300%	53
Total		6,904

TOTAL **11,007**

C. Strategic Objectives, Goals and Measures

Strategic Objectives:

a. To increase the number of children in Connecticut with health insurance by expanding Medicaid (HUSKY Part A) coverage and creating a new health insurance program for previously uninsured children (HUSKY B).

HUSKY A: Connecticut has expanded Medicaid eligibility for children ages 14-18 years with a family income up to and including 185% FPL.

HUSKY B: Connecticut has designed a new health insurance program for children up through 18 years of age whose family income is over 185% FPL.

b. To maximize participation in HUSKY Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.

HUSKY A and B have a single, simplified application that is 2 pages (2 sides each) long. All applications can be submitted to Benova, our single point of entry servicer. Benova will screen the applications and if the family appears to be HUSKY A eligible, the application will be forwarded to the appropriate regional office of the Department of Social Services ("the Department"). If the family appears to be HUSKY B eligible, Benova will retain the application and upon further review make a determination of

eligibility. Families are not precluded from applying through any regional office of the Department and many new enrollees apply for HUSKY in this way. If the family applies to the regional office of the Department and it is a HUSKY A case, the Department will make the eligibility determination without sending the case to Benova for a screening. Thus, although Benova received almost 11,000 applications through calendar year 1998, there were many more applications made to the HUSKY program.

Enrollment for both HUSKY A and B is for a year unless the child loses eligibility due to specified criteria. Presumptive eligibility will be available for HUSKY A before the end of FFY 99. Please see "Outreach" (E, below) for a discussion of our outreach efforts.

c. To promote the health of children through a health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.

HUSKY B benefits combine the most generous benefits offered under the three state employee options (Blue Cross, MD Health Plan, and Kaiser Permanente) and includes comprehensive preventive services. For both HUSKY A and B, the Medicaid definition of medical necessity will prevail.

For children with intensive physical and/or behavioral health needs, additional benefits may be available through the HUSKY Plus plans (see below).

d. To assist those children enrolled in HUSKY Part B who have special physical and behavioral health care needs to receive appropriate care through two supplemental plans (HUSKY Plus).

For children enrolled in HUSKY B who have intensive physical and/or behavioral health needs and whose family income is over 185% FPL and up to and including 300% FPL, additional benefits are available through two supplemental health insurance programs, HUSKY Plus Physical and HUSKY Plus Behavioral.

e. To design the HUSKY Plus program in a way that will maximize coordination between the HUSKY Part B and HUSKY Plus by integrating basic health care needs into the care provided for intensive health care needs and, whenever possible, building upon existing therapeutic relationships with Title V providers.

For those children enrolled in HUSKY B who have intensive physical and/or behavioral health needs, referral can be made to the HUSKY Plus programs by the health plan in which the child is enrolled. The centers with which the Department contracts for the Plus programs will determine eligibility based upon a clinical assessment. If the center determines the child is clinically eligible, the child will be enrolled in the appropriate HUSKY Plus program. The HUSKY B managed care plan is part of the team which develops the plan of care for the child in the HUSKY Plus program. The child remains enrolled in its HUSKY B managed care plan for health care that is not related to the intensive physical and/or behavioral health need that the child has.

By statute, the HUSKY Plus Physical program has been tied directly to Connecticut's Title V program so that clinical eligibility and covered services would be consistent between them. This design allows for existing therapeutic relationships in Title V to be carried over to HUSKY Plus if a child is switched from one program to another. At this point, 100% of children who are in HUSKY Plus who were formerly in Title V have continued with the same specialty provider.

Performance Goals:

a. To increase the number of children covered by health insurance.

Please see enrollment statistics in "Reduction of Low-Income Children without Insurance" (B, above).

b. To maximize participation in HUSKY Parts A & B through:

(i) Expanding Medicaid (HUSKY Part A) enrollment of uninsured children up through age 18 years who are under 185% of the federal poverty level.

Overall enrollment increased in HUSKY A by 2,964 children during July 1, 1998 through September 30, 1998. The increase for October 31, 1998 through December 31, 1998 was 5,741 children.

(ii) Increasing the number of insured children 18 or under who are between 185% and 300% of the federal poverty level.

Enrollment in HUSKY B between July 1, 1998 and September 30, 1998 was 776 for children in families with income over 185% FPL and up to and including 235% FPL and 325 for children in families with income over 235% FPL and up to and including 300% FPL for a total of 1,101.

Enrollment in HUSKY B between October 1, 1998 and December 31, 1998 was 761 for children in families with income over 185% FPL and up to and including 235% FPL and 349 for children in families with incomes over 235% FPL and up to and including 300% FPL for a total of 1,110.

c. To promote the health of children through a comprehensive health benefits package through:

Matching or exceeding the statewide average of the percentage of children in HUSKY Parts A & B who receive immunizations by age 2, meet or exceed state standards for well-child care, with a goal of at least 80% of children receiving all recommended well-child visits.

Connecticut's CHIP program was launched in June of 1998 with enrollment beginning July 1, 1998. As of September 30, 1998, our CHIP program had been in operation for

only a few months. Thus, we are not able to provide any immunization data for the CHIP program for FFY 98. Please see "How Performance will be Measured" (# 3, below) for a discussion of how this data will be collected and measured.

d. To assist children with special physical and behavioral health through HUSKY Plus through:

(I) 100% of referrals to HUSKY Plus to have eligibility determinations within 21 days.

All eligibility determinations for referrals to HUSKY Plus within FFY 98 were made within 21 days.

(ii) Tracking the percentage of referrals to HUSKY Plus which are accepted or denied.

Acceptance into HUSKY Plus programs is based upon a clinical determination of intensive physical or behavioral health needs since the child must already be enrolled in HUSKY B. Of the 2 referrals to HUSKY Plus in FFY 98, both children were determined clinically eligible and were accepted. Thus, the percentage of those accepted was 100%.

Acceptance into HUSKY Plus has remained at 100% for cases since October 1, 1998. There are now a total of 17 children in the HUSKY Plus programs.

(iii) 100% of children with the following conditions receiving care according to individual needs and professional guidelines:

(a) Cystic Fibrosis under ICD 9 CM 277.0.

There have been no children enrolled in HUSKY Plus with this diagnosis.

(b) Cerebral Palsy under ICD 9 CM 343.

There was one child enrolled in HUSKY Plus during FFY 98 with this diagnosis. Since October 1, 1998 two more children with this diagnosis have been enrolled. All three of these children are receiving care according to individual needs and professional guidelines.

(c) Major Depression under DSM IV 296.30 through 296.36.

There were no children enrolled in HUSKY Plus during FFY 98 with this diagnosis. Since October 1, 1998 one child with this diagnosis has enrolled in HUSKY Plus and that child has been receiving care according to individual needs and professional guidelines.

(iv) Maximizing coordination between HUSKY Part B and HUSKY Plus through:

(a) 100 % of children in HUSKY Plus who receive case management.

One hundred percent of the children in HUSKY Plus during FFY 98 received case management.

(b) 100% of children in HUSKY Plus, who were formerly covered by Title V, who will continue to have the same specialty provider.

One hundred percent of the children in HUSKY Plus who were formerly covered by Title V have continued with the same specialty provider.

3. How Performance will be Measured:

The state, through a contract with an external quality review entity, Qualidigm (formerly Connecticut Peer Review Organization), will conduct an annual evaluation based on an analysis of the program measurer, a sampling of patient charts, and a patient satisfaction survey. We have been coordinating with Qualidigm concerning their responsibilities for data collection, submission of plan-specific utilization reports, and review and evaluation of individual cases. In addition, a meeting has been scheduled for mid-February for Qualidigm, the Medical Care Plans and the Department to work on coordination issues.

D. Barriers

Because significant efforts have been dedicated to designing and implementing a comprehensive health care program under CHIP, as well as significant efforts to make the HUSKY Plan known to and available to Connecticut families, identification of barriers to successful enrollment into this program and the elimination of those barriers if possible is of great importance to us.

Four barriers identified by Connecticut are discussed below. Some of these barriers are shared with other CHIP programs and other barriers may be considered unique to the Connecticut plan:

1. Stigmatization:

The social stigmas associated with Medicaid continue to endure not only for the Medicaid eligible population but also for the CHIP eligibles. Notwithstanding Connecticut's efforts to rename the program as the HUSKY Plan for both Medicaid and CHIP, the "welfare" stigma is recurrent. Potential eligibles are resistant to participate in government programs perceived as "handouts." Providers also associate CHIP with the Medicaid program. Discussions with other states confirm a similar experience.

2. Immigration and Naturalization Service (INS) issues:

There is concern among families that, because of welfare reform, the State will report them to the INS. Although we do not ask for the immigration status of the parent to

determine the eligibility of the child, parents who are not in this country legally are reluctant to provide employer information or social security numbers for their children for fear that they (the parents) will be reported to the INS. This fear effectively deters application and therefore enrollment. Again, other states with immigrant populations corroborate this situation.

3. Outreach approaches:

Like other CHIP programs, Connecticut's HUSKY Plan targets the uninsured population, yet, unlike many other CHIP programs, Connecticut seeks to provide insurance coverage for a population with an income of over 185% FPL. There is no income cap for eligibility. We believe that the traditional models and entities involved in outreach are insufficient to effect successful enrollment for this group of people. This is particularly crucial when targeting teens and specific racial and ethnic groups in non-Medicaid socio-economic strata.

4. Family choices.

There is concern that a barrier to enrollment may reside in the difficult choices that families must make regarding insurance coverage. In some instances, families must choose between costly coverage for the whole family and low cost coverage for the child(ren) only. In addition, the crowd out provision that allows HUSKY enrollment only after a waiting period of six months with no insurance may be a deterrent to enrollment. The waiting period is generally seen as financially and/or medically risky for families, especially for families with children who have intensive physical and/or behavioral health care needs.

Connecticut is developing new strategies to remove or lessen the barriers to enrollment through a variety of approaches. Through a Request For Application process, the HUSKY Plan has contracted with several entities and community organizations that will bring innovative ideas to market the program. In addition, we continue to work closely with the Robert Wood Johnson Foundation outreach grantee in the state to coordinate and enhance the outreach efforts. We are in the process of revising the HUSKY application to remove unnecessary requirements and clarify any misconceptions. We continue to foster relationships with federal agencies in Connecticut through a collaborative effort begun in October 1998.

E. Outreach and Crowd-Out

1. Outreach:

Connecticut has simplified the HUSKY application process. As discussed in “Strategic Objectives” (C1, above), HUSKY A & B have a single application that is 2 pages (2 sides each) long. All applications can be submitted to Benova, our single point of entry servicer. Benova will screen the applications and if the family appears to be HUSKY B eligible, Benova will review the application in more depth and make a determination of

eligibility. If the family appears to be HUSKY A eligible, the application will be forwarded directly to the appropriate regional office of the Department for an eligibility determination. The families are not required to personally appear at either Benova or the Department.

It is important to note that families are not precluded from applying in person or over the telephone to a regional office of the Department. Many new enrollees apply for HUSKY in this way, probably because it had been the standard procedure for many years. If a family applies to the regional office of the Department and it is a HUSKY A case, the Department will make the eligibility determination without sending the case to Benova for a screening. Thus, although Benova received almost 11,000 applications through calendar year 1998, there were many more applications made to the HUSKY program.

Besides actually filling out the application manually, families applying for HUSKY can call a toll-free number and, through a question and answer process, have Benova take the information over the telephone. Benova will then print out the application with the information provided and send it to the family for verification and signature. Once the application is returned to Benova, the same screening process that is discussed above will be followed.

Neither HUSKY A nor B requires a financial assets test and many of the documentation requirements that were a standard part of the application process in the past have now been eliminated.

While all eligibility determinations are made by Benova at its Connecticut headquarters or at one of the Department's regional offices, assistance with applications is available at various sites around Connecticut. This can occur during community presentations by outreach facilitators who work for or are under contract with Benova, InfoLine, or entities under outreach contracts with the Department. However, we encourage families to make applications over the telephone with Benova since they will then be able to have their questions answered by the entity that will be doing the initial screening.

While the number of people who know about Connecticut's HUSKY (combined CHIP/Medicaid) program is impossible to measure, we know that awareness has been building significantly since June 1998, when our CHIP program began. A concrete indication of in-depth awareness can be found in the number of completed applications that have been processed by Benova, our new single point of entry servicer. Benova had received 10,900 applications through the end of December 1998. Since the single point of entry service is a new process for receipt of applications, we believe that the receipt of almost 11,000 applications through this method to be commendable.

The number of requested applications and brochures is harder to measure because it includes not only calls received by two toll-free numbers (single point of entry service contractor and information/referral contractor), but also the Department as administering agency, and many local private and municipal health and human service organizations that are distributing brochures and applications. To date, more than 200,000 brochures

have been distributed to families and organizations throughout the state. In addition, nearly 750,000 information cards have been distributed, mainly through the Department of Motor Vehicles and school systems. Our hotlines are receiving approximately 3,400 new-inquiry calls per month.

Since June 1998, Connecticut has funded more than $250,000 in advertising, printing and promotional support to HUSKY outreach.

Through a Request for Application process, the Department has awarded ten grants for community-based outreach. There are five grants at $20,000 for programs based in Bridgeport, Danbury, New Haven, Waterbury and Norwich, three grants at $50,000 for eastern and south-central Connecticut and the Greater Naugatuck Valley, and two grants at $100,000 to focus on adolescents and children through school-based health centers. In addition, another $50,000 is earmarked for areas that were not covered in grant applications, particularly the state's rural northwestern corner. The Department's total investment in these grants is $500,000.

A broad, statewide coalition, with the Children's Health Council as lead agency, and with the Department providing strong support, has received funding from the Robert Wood Johnson Foundation under the Covering Kids initiative for statewide interventions and pilot interventions in Bridgeport and Stratford and in a five-town area that includes Manchester, East Hartford, Vernon, Hebron, and Glastonbury. The local pilots will launch intensive, community-wide efforts to enroll uninsured children, with a special emphasis on adolescents and children in immigrant families.

During the first six months of the program, Connecticut launched a multi-faceted outreach initiative that continues to develop and diversify. The aim is to inform parents of uninsured children that it is convenient and easy to apply for free or low-cost health coverage. Supporting this effort is a continued emphasis on ensuring user-friendliness. For example, the combined HUSKY application was reduced to four pages at the program's kickoff, and is being further revised to remove unnecessary requirements and to clarify any misconceptions. Call-in application options and website access are proving to be popular offerings. A customer satisfaction survey is currently being conducted to qualify program and outreach measures. Complete information on specific outreach measures is attached.

2. Crowd-out:

Connecticut's crowd-out provision applies to discontinuance of employer-sponsored insurance by applicants or employers of applicants for purposes of participation in the HUSKY B program. An application may be disapproved if it is determined that a child to be covered under HUSKY B was covered by employer-sponsored insurance within the last six months, unless the reason for discontinuance was unrelated to the availability of HUSKY B.

Connecticut has not seen a significant problem with families dropping employer-sponsored health insurance in large numbers in order for their children to become eligible for HUSKY Part B. During the first six months of operation, July 1 through December 31, 1998, there were 34 children specifically denied for having been covered by employer-sponsored insurance within the last six months. (In addition, there were 395 application denials for HUSKY B because the children actually had health insurance at the time of the application.)

Connecticut's single point of entry service contractor sends letters to employers of a sample of applicants to check on the accuracy of application statements. To date, several hundred verification letters to employers have not revealed that applicants are hiding their insurance status to avoid crowd-out-related ineligibility. Only one letter generated a possible conclusion of inaccuracy and it was concluded to be a misunderstanding.

Outreach for Connecticut's HUSKY program generally includes references to crowd-out, but does not emphasize it because the overarching goal is to generate calls and applications. Crowd-out factors are explained to applicants when they call the toll-free information and application hotlines. Crowd-out limitations and hardship exceptions are also covered in supplementary written materials and handouts. Similarly, crowd-out is explained in training sessions for human service professionals and outreach workers. With outreach, Connecticut is seeking to 'cast a wide net' to capture all eligible children in an application pool. We do not want parents to try to figure out the complex area of crowd-out and mistakenly eliminate their children from professional review of eligibility. As discussed in "Barriers" (D, above), there is some concern that families will not even consider applying for HUSKY if they believe they must go without insurance for their child(ren) for six months before HUSKY B eligibility is a possibility.

Less measurable than the small number of denials related to crowd-out would be the number of applications that are not received in the first place because parents may have heard about crowd-out. It is believed that such a number would be negligible for the reasons that crowd-out and hardship exceptions are very complex matters to understand and that outreach messages strongly advocate that parents simply call the hotline to learn about applying for children's health insurance.

F. Technical Assistance Needed from HCFA

The CHIP legislation has allowed Connecticut the flexibility to design a health insurance program unique to the needs of Connecticut. We have risen to the challenge and have successfully enrolled uninsured children into our new HUSKY B health insurance program, as well as made more children eligible for HUSKY A. However, there are ways HCFA could assist us.

Identification of the Uninsured:

Considerable discussion has taken place around the problematic uses of the Current Population Survey (CPS) to determine the federal allotment to the States. Connecticut

would welcome assistance from HCFA in this regard, since use of CPS data adversely affects the smaller states such as Connecticut. We suggest that HCFA could provide assistance with the accurate identification and analysis of the number of uninsured children and families. While individual states could conduct surveys within their own borders, it would be useful to have national studies of a broader nature using a uniform definition of "uninsured." The study could also systematically address the question of why some people do not enroll in Medicaid/CHIP across the country.

2. Flexibility with the 10% Cap:

While the HUSKY Plan has been successful in its implementation, Connecticut has devoted significant efforts to meet the outreach requirements and the start up costs of the program. The 10% cap is an unrealistic expectation when confronted with the efforts required during the first year of operation. We suggest that additional flexibility to the 10% cap can be built into the CHIP program for states.

3. Simplifying Applications:

Connecticut is in the process of revising its CHIP/Medicaid application to remove or lessen any barriers to enrollment. Given that the application is for a combined program, a number of difficulties have arisen. We are concerned about our ability to safeguard the integrity of both programs without adversely affecting continued increase in enrollment.

We are struggling with finding the balance between complying with Medicaid requirements and the increased flexibility of the CHIP program. Because the definition of "targeted low-income child" under CHIP requires a finding that the child is not eligible for medical assistance under Title XIX, states must first screen children for Medicaid. To determine Medicaid eligibility brings in a whole host of stringent federal requirements. These requirements translate into questions on our application, answers to which are not necessary for eligibility for CHIP if it were not for the requirement that we screen out Medicaid eligibility. These additional questions can be seen as unnecessarily intrusive to the population we are trying to attract into the CHIP program. While HCFA voices concern that the states need to loosen application restrictions and requirements for CHIP applicants, we are concerned that loosening application restrictions will open us up to serious problems if a CHIP enrollee is later found to be Medicaid eligible.

In fact this dichotomy between stringent requirements for Medicaid and flexibility for CHIP has implications throughout the whole Medicaid Quality Control program. Along with its direction to states to loosen application restrictions for CHIP applicants, HCFA needs to provide the equivalent flexibility in the quality control requirements for the CHIP/Medicaid programs.

Presumptive eligibility:

Federal requirements restrict who can determine presumptive eligibility for Medicaid. Connecticut is thus precluded from using Benova, our single point of entry service

contractor, to grant presumptive eligibility. In effect, our first screener of all applications has to send potential Medicaid applications elsewhere, building a delay into our application system. How much more efficient it would be to have our first screener, the screener who has already made an initial determination of eligibility, able to make the formal determination of presumptive eligibility.

We suggest that the federal government broaden its restrictive definition of who can grant presumptive eligibility, thus allowing us to further streamline our eligibility process. We believe that removing this barrier to effectively utilize our first eligibility screener would make our system considerably more responsive to applicants and could thereby affect enrollment in a positive way.

G. Other Relevant Concerns

There is legislative and public interest in Connecticut in providing health care coverage to the uninsured parents of children who qualify for our CHIP program. It has been stated that parents are more likely to apply for health insurance coverage for their children and more likely to access the health care that is available when all the members of the family are similarly covered. We note that Wisconsin recently was given approval to expand its CHIP program to cover the parents of CHIP eligible children. Connecticut may explore this possibility.

A summary of the Technical Advisory Panel meeting, “How Can We Build Partnerships with State Outreach Activities?," is included as an attachment. This report provides additional states' concerns with a number of issues ranging from outreach to data to quality assurance.